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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS67234.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This Requirement is not met as evidenced by: The facility identified a census of 55 residents. The sample included 14 residents. Based on observation, record review and staff interview, the facility failed to develop an Activities of Daily Living (ADL) care plan for one (#72) resident in the sample. Findings include: - The electronic medical diagnosis dated	F 279		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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7-29-2013 for resident #72 listed Schizoaffective Disorder (Combination of schizophrenia symptoms (hallucinations - sensing things while awake that appear to be real, but instead have been created by the mind or delusions - an untrue persistent belief or perception held by a person although evidence shows it is untrue) and of mood disorder symptoms, such as mania or depression), Major Depressive Disorder with Psychotic Behavior (abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness and hopelessness characterized by a gross impairment in reality testing), and Bipolar Disorder (a major mental illness that causes people to have episodes of severe high and low moods).

The 8-5-13 Admission Minimum Data Set (MDS) 3.0 documented the Brief Interview for Mental Status score of 15 which indicated cognition was intact; the resident was independent and required no setup or physical help from staff with personal hygiene; the resident was independent with bathing and required no setup or physical help from staff.

The clinical record lacked evidence of a Care Plan for ADL's specifically shaving.

The electronic ADL flow sheet dated 7-29-13 through 8-19-13 documented the resident was independent with personal hygiene.

During an observation on 8-15-2013 at 1:37 P.M. the resident sat in his/her wheelchair in the hallway, and long gray facial hairs were observed on the resident's chin.

Observation on 8-19-13 at 11:56 A.M. revealed

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F 279	Continued From page 2 the resident stood in medication line, and long gray facial hairs were observed on resident's chin and around mouth area. During an interview on 8-19-2013 at 1:15 P.M., direct care staff O stated he/she was independent with his/her personal hygiene. Staff tend to shave residents when facial hair started to show. Staff usually shave residents in the mornings. Some residents were allowed to have razors and others cannot. Interview on 8-19-2013 at 2:39 P.M., direct care staff P stated if residents do not get shaved on the day shift staff do it in the evening. Sometimes the resident needed cueing with personal hygiene. The residents liked to shave himself/herself when he/she wanted to do it. Interview on 8-19-2013 at 1:49 P.M., licensed nursing staff H stated the resident was independent with his/her personal hygiene. Staff would help him/her with shaving. Shaving took place with AM cares and anytime they needed it. The resident did not have a care plan for ADLs or for personal hygiene. Interview on 8-19-2013 at 3:10 P.M., licensed nursing staff I stated the resident was independent with his/her personal hygiene. He/she did not shave himself/herself. Direct care staff shave residents on shower days and as needed. The resident did not have a care plan on personal hygiene because he/she was independent with everything. Interview on 8-19-2013 at 3:43 P.M., administrator nursing staff D stated I do not see a care plan for personal hygiene. The resident did not have an intervention for shaving.	F 279		

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F 279	Continued From page 3 The facility failed to provide requested policy the on ADLs for shaving. The facility failed to develop a plan of care for ADLs specifically shaving for this resident.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: The facility identified a census of 55 residents. The sample included 14 residents. Based on observation, interview, and record review, the facility failed to revise the plan of care for falls for one (#13) of 3 residents reviewed for falls. Findings included:	F 280		

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F 280	Continued From page 4 - The electronic physician order sheet dated 4/9/13 for resident #13 revealed the following diagnoses: epilepsy (a brain disorder in which a person had repeated seizures), essential tremors (a degenerative disorder of the central nervous system with features of a tremor of the arms or hands during voluntary movements such as eating and writing), Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, forward flexion of the trunk, loss of postural reflexes and muscle rigidity and weakness), and diabetes with neuropathy (type of nerve damage that could occur with high blood sugars which injure nerve fibers throughout the body, most often nerves in the legs and feet). The quarterly Minimum Data Set (MDS) 3.0 with the assessment reference date (ARD) of 5/9/13 listed the brief interview for mental status (BIMS) score of 13, which indicated intact cognition. He/she was independent with activities of daily living (ADLs), had no functional limitations with range of motion, unsteady with balance for transfers and walking but was able to rebalance without assistance, and had two injury (but not major) falls since the last assessment. The quarterly Minimum Data Set 3.0 with the assessment reference date of 7/25/13 listed the BIMS score of 13, which indicated intact cognition. He/she was independent with ADLs, had no functional limitations with range of motion, unsteady with balance for transfers and walking but was able to rebalance without assistance, and had one non-injury fall since the previous assessment. The Care Area Assessment dated 8/18/13 for falls listed the resident had 3 non-injury falls	F 280		

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during this time (1-16, 1-23, 2-16) . He/she was impulsive, had a history of falls from getting up too fast and tangling up his/her feet with each other. Lisinopril (used to treat high blood pressure) was discontinued as a result of trial period and monitoring of blood pressure that supported orthostatic hypotension (blood pressure suddenly falls with standing up or stretching), with only one fall to date after discontinuing the Lisinopril. The resident was unable to feel his feet and lower legs due to peripheral vascular disease (any abnormal condition affecting the blood vessels) and insulin dependent diabetes mellitus (when the body could not use glucose, there was not enough insulin made or the body could not respond to the insulin and was dependent on the medication to control the body's blood sugar), had tremors and received psychotropic medications. He/she made quick movements that jeopardized his/her balance or pose him/her at risk for tripping. The resident had no concern about his/her potential for falls and continued to deny being a risk for falls.

The care plan for falls dated 8/8/13 noted the resident had the potential for injury from falls because of a history of falls, poor balance, unstable blood sugars, peripheral neuropathy, impaired cognition due to mental illness and mild mental retardation. The resident was often non-compliant and tended to keep too many personal items on the bed, additional risk factors were tremors, Parkinson's disease, cataracts (a clouding of the lens of the eye), and seizure disorder. Staff"s fall interventions were before the resident went to town, he/she needed to have his/her blood sugar checked and if it was below 100, staff to give the resident a snack, if the blood sugar was between 100-200 then he/she could

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F 280	Continued From page 6 walk by him/herself. The nurse's note dated 3/31/13 at 9:39 P.M. noted the resident walked to town today with no issues. The nurse's note dated 4/7/13 at 4:43 P.M. noted the resident lost his/her balance and fell outside in front of the facility. The resident hit his/her head and received a slight abrasion to the forehead, right temple area, and to fingers of the left hand. Nurse's note dated 4/14/13 at 2:44 P.M. noted the resident was in front of the building and tripped over a concrete parking curb, fell sideways and down to the ground. He/she received a skin tear to the back of the head, denied pain, was able to assist staff into a standing position and walked into the building. The nurse's note dated 4/20/13 at 1:24 P.M. noted the resident requested to go downtown, staff informed the resident that he/she could not because of being a fall risk. The resident later requested to go outside and walk around on the gravel road in front of the facility. Staff told the resident that he/she could not do that because of having fallen twice in the past 3 weeks, one of the falls on the gravel road. Staff informed the resident he/she needed to be with staff when walking outside. Resident observed on 8/15/13 at 7:30 A.M. in the dining room, listening to country western music. At 8:05 A.M., the resident walked out of the dining room, gait fairly steady at this time. On 8/15/13 at 1:25 P.M. observation revealed the resident walked back to his/her room, did propel	F 280		

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F 280	Continued From page 7 slightly forward with a fairly rapid gait. Interview on 8/19/13 at 2:20 P.M. with direct care staff Q said the resident had several falls. We have told him/her to slow down when he/she walked but he/she seemed to become unbalanced while walking and fell. He/she said the resident did not go downtown anymore unless he/she went on the bus, he/she was to unstable to walk to town anymore. Interview with direct care staff R on 8/19/13 at 4:03 P.M. revealed if the resident wanted to go outside, the staff tried to make sure he/she stayed on the sidewalk and away from the gravel and if he/she was near the gravel staff should be with the resident. Direct care staff R said he/she did not think the resident walked downtown anymore because he/she was too unsteady. Interview on 8/19/13 at 3:47 P.M. with licensed staff I said the resident liked to walk downtown but we checked his/her blood sugar first and if it was low then he/she had to eat something first. We let him/her go downtown but if he/she had falls recent to wanting to go downtown, then staff had to accompany him/her. Interview with administrative nursing staff D on 8/19/13 at 4:40 P.M. said the resident did not walk downtown anymore with or without staff. The resident rode the bus downtown and then staff walked with him/her while he/she was there. The facility failed to revise the care plan to reflect the resident was no longer permitted, due to safety reasons, to ambulate downtown.	F 280		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS	F 311		

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F 311	Continued From page 8 A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This Requirement is not met as evidenced by: The facility identified a census of 55 residents. The sample included 14 residents. Based on observation, record review and staff interview, the facility failed to assess Activities of Daily Living (ADLs) specifically shaving and provide cueing for one (#72) resident in the sample. Findings include: - The electronic medical diagnosis dated 7-29-2013 for resident #72 listed diagnoses of Schizoaffective Disorder (Combination of schizophrenia symptoms (hallucinations - sensing things while awake that appear to be real, but instead have been created by the mind or delusions - an untrue persistent belief or perception held by a person although evidence shows it is untrue) and of mood disorder symptoms, such as mania or depression, Major Depressive Disorder with Psychotic Behavior (abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness and hopelessness characterized by a gross impairment in reality testing), and Bipolar Disorder (a major mental illness that causes people to have episodes of severe high and low moods). The 8-5-13 Admission Minimum Data Set (MDS) documented the Brief Interview for Mental Status (BIMS) score of 15 which indicated cognition was intact; the resident was independent and required no setup or physical help from staff with personal	F 311		

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hygiene; the resident was independent with bathing and required no setup or physical help from staff.

The clinical record lacked evidence of a care plan for shaving.

The electronic ADL flow sheet dated 7-29-13 through 8-19-13 documented the resident was independent with personal hygiene.

During an observation on 8-15-2013 at 1:37 P.M. revealed the resident sat in his/her wheelchair in the hallway, and long gray facial hairs were observed on the resident's chin.

Observation on 8-19-13 at 11:56 A.M. revealed the resident stood in medication line, and long gray facial hairs were observed on resident's chin and around mouth area.

During an interview on 8-19-2013 at 1:15 P.M., direct care staff O stated the resident was independent with his/her personal hygiene. Staff tend to shave residents when facial hair started to show. Staff usually shaved residents in the mornings. Some residents were allowed to have razors and others could not.

Interview on 8-19-2013 at 2:39 P.M., direct care staff P stated if residents did not get shaved on the day shift staff did it in the evening. Sometimes the resident needed cueing with personal hygiene. He/she liked to shave himself/herself when he/she wanted to do it.

Interview on 8-19-2013 at 1:49 P.M., licensed nursing staff H stated the resident was independent with his/her personal hygiene. Staff would help him/her with shaving. Shaving took

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F 311	Continued From page 10 place with AM cares and anytime they needed it. The resident did not have a care plan specifically for ADLs or for personal hygiene. Interview on 8-19-2013 at 3:10 P.M., licensed nursing staff I stated the resident was independent with his/her personal hygiene. He/she did not shave himself/herself. Direct care staff shaved residents on shower days and as needed. The resident did not have a care plan on personal hygiene because he/she was independent with everything. Interview on 8-19-2013 at 3:43 P.M., administrator nursing staff D stated I do not see a care plan for personal hygiene. The resident did not have an intervention for shaving. The facility failed to provide requested policy on ADLs specifically for shaving. The facility failed to assess and assist this resident with shaving.	F 311		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This Requirement is not met as evidenced by: There facility identified a census of 55 residents.	F 315		

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F 315	Continued From page 11 Sample size included 14 residents of which 2 were reviewed for incontinence. Based on observation, record review, and interview the facility failed to assess and provide effective interventions to manage 1 (#11) resident of the sample. Findings included: - The quarterly Minimum Data Set 3.0 with assessment reference date of 7/10/13 for resident #11 revealed a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition, was independent with activities of daily living (ADLs), was not on a toileting plan, was occasionally incontinent of urine, and received a diuretic daily. The Care Area Assessment (CAA) for urinary incontinence dated 2/21/13 noted the resident had 3 documented occurrences of urinary tract infection this look back period, used briefs for management of incontinence and was most often independent with toileting. This was not a change as the resident had urinary difficulties in the past. The resident received a diuretic daily. The CAA dated 2/21/13 for ADLs noted the resident needed structure and assistance to complete ADLs. He/she was self-motivated and like to maintain appropriate dress and hygiene. The resident completed most of his/her ADLs with out staff assistance. The care plan dated 7/30/13 for altered non-pressure skin integrity related to urinary incontinence noted the resident liked to wear a brief through out the day, resident to notify staff when changed brief so staff could remove it from the resident's room. Staff to observe for signs	F 315		

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and symptoms of skin irritation or infection, provide thorough skin care after incontinent episodes and apply barrier cream.

Review of direct care staff electronic charting for urinary incontinence revealed the resident was incontinent approximately 7 to 8 times monthly.

Review of Quarterly Interdisciplinary Resident Review dated 7/7/13 failed to complete a bladder evaluation, noted the resident was independent with ADLs, requested assistance with showering due to history of falls, had occasional urinary incontinence and was able to change his/her own brief.

A bladder assessment dated 2/2/12 listed the resident received anti-psychotic medications and a diuretic. The last urine analysis was on 6/22/11, resident had urge incontinence, had loss of urine on the way to the bathroom and had nocturia greater than twice. Staff reviewed this bladder assessment last on 5/16/13 and continued that the resident was occasionally incontinent of urine, was independent with toileting, wore briefs, able to change them independently and staff to remind the resident to not leave wet brief in the trash can in the resident's room.

Observed during the a resident interview on 8/14/13 at 9:15 A.M. a strong stale urine odor.

Observation on 8/15/13 at 7:47 A.M. revealed several paper towels, napkins, and a blue disposable pad placed on over pad in the chair in the resident's room.

Observation on 8/19/13 at 8:02 A.M. noted in a towel and blue chux over the pad on the chair in

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the resident's room. There was a strong urine odor.

An interview on 8/14/13 at 2:40 P.M. with the resident revealed he/she wore disposable briefs and changed them him/herself. He/she said he/she used to wear disposable pads but they were not enough and he/she wanted to be assured the urine would not soak through.

Interview with direct care staff Q on 8/19/13 at 2:00 P.M. said the resident was incontinent at times, wore briefs, and ate and drank well. He/she said the resident never asked the staff to take the wet briefs from his/her room. Direct care staff Q said he/she removed them when he/she was in the room and placed them in the soiled utility room. He/she said that he/she went in the resident's room often and removed the pads and towels from the resident's chair and put down some clean ones. He/she said they have a definite urine odor.

Interview with direct care staff R at 4:00 P.M. on 8/19/13 said the resident was independent with ADLs and the only thing we helped the resident with was to lift their legs up onto the bed at night. The resident changed his/her briefs and placed them in the trash can, we pick up everyone's trash at the end of the shift so we did the resident's trash and briefs then. He/she did not call us to empty the trash can after he/she placed a brief in there. The resident also changed the pads to the chair by his/her bed.

Interview with licensed nursing staff I on 8/19/13 at 3:52 P.M. said the resident wore briefs and had occasional incontinence. He/she said we do not prompt the resident to toilet, he/she was independent and even placed the pads he/she

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F 315	Continued From page 14 used to protect the chair, in the chair him/herself. Interview with administrative nursing D on 8/19/13 at 5:30 P.M. said a 3 day voiding diary was only done on new admissions or if there was a significant change in status. He/she said the resident lived here for 16 years or so and we have not done another voiding diary but we do review the urinary assessments quarterly. The facility provided policy for Bladder Management Program dated 2006 stated "to develop toileting schedule with the resident's participation, toileting schedules would be as close to the resident's customary routine as possible. Observe and record the resident's voiding pattern and revise toileting schedule to meet resident's needs. This should be done until a routine is established. Enter the plan for management of urinary incontinence as an approach under the appropriate underlying problem on the resident's care plan." The facility failed to accurately assess and establish a voiding pattern specific for this resident with incontinence.	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329		

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resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This Requirement is not met as evidenced by:
The facility identified a census of 55 residents. The sample was 14 residents, 5 of which were reviewed for medications. Based on observation, record review and staff interview, the facility failed to monitor bowel movements for two residents (#13, #24) and failed to develop a black box warning care plan for one resident (#13) of the sample.

Findings included:

- The electronic medical diagnosis dated 10-10-2012 for resident #24 listed diagnoses of constipation.

The 6-12-2013 Annual Minimum Data Set documented the Brief Interview for Mental Status score of 15 which indicated cognition intact.

The 6-24-2013 Care Area Assessment (CAA) for Psychotropic Drug Use documented the resident took Senokot S routinely and PRN (as needed) Milk of Magnesia for constipation.

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F 329	Continued From page 16 The electronic Physicians Order Sheet (POS) documented Senokot S 8.6-50 milligrams 1 tablet by mouth at bedtime everyday for constipation with the start date 10/7/2011. The 1-6-2012 Care Plan for the resident at risk for constipation documented staff to make sure he/she had a bowel movement at least every three days and staff to give the resident medications as ordered routine Senokot and PRN Milk of Magnesia. The electronic Resident Continence Log revealed the resident did not have a bowel movement from 7-2-2013 through 7-5-2013 to equal a total of 4 days. Observation on 8-15-13 at 7:35 A.M. revealed the resident in the dining room verbally interacting with staff and residents in a pleasant conversation. At 1:34 P.M. revealed the resident in his/her room putting away their laundry. Observation on 8-19-13 at 10:00 A.M. revealed the resident in the dining room area picking up the wet floor signs and having pleasant conversation with a peer. Interview on 8-19-13 at 1:15 P.M., direct care staff O stated on each shift before it ended staff went around and asked the residents if they had a bowel movement. Staff chart the bowel movements on the kiosk machine (charting system) and on paper. Interview on 8-19-13 at 2:39 P.M., direct care staff P stated every night staff went around and asked each resident if they had a bowel movement and then staff chart that on the kiosk machine.	F 329		

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F 329	Continued From page 17 Interview on 8-19-13 at 1:49 P.M., licensed nursing staff H stated staff asked residents about bowel movements. Staff document bowel movements in care tracker (charting program). The protocol for bowel movements was if there was no bowel movement in the last nine shifts staff discussed this in the start up meeting; staff gave Milk of Magnesia if that did not work then a suppository was given and worse case scenario an enema was given. Interview on 8-19-13 at 3:10 P.M., licensed nursing staff I acknowledged there was no bowel movement documented for four days (7/2/2013 through 7/5/2013) and stated I did not have any intervention documented for that time period. Interview on 8-19-13 at 3:43 P.M., administrator nursing staff D stated sometimes the residents refused to tell us if they had a bowel movement. To my knowledge he/she has not had a problem. On the Clinical Startup check list dated 7-2-13, 7-3-13, 7-4-13 and 7-5-13 the resident was not on the list for not having a bowel movement. On the fourth day staff gave whatever the resident had ordered. The facility provided 2006 dated Bowel Management Program procedure revealed a daily bowel movement was not necessary, but a resident should not be allowed to go for more than three days without a bowel movement. The facility failed to monitor bowel movements for this resident. - The electronic physician order sheet (POS) for resident #13 dated 4/9/13 revealed the following diagnoses: gastroparesis (food remained in the	F 329		

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stomach longer time than normal), paranoid schizophrenia (a psychotic disorder believed to be heavily influenced by anxiety or fear to the point of irrational thinking, fragmentation of thought, perception and emotional reaction), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), and dementia with behavioral disturbances (progressive mental disorder characterized by failing memory, confusion and also with behavioral symptoms).

The quarterly Minimum Data Set 3.0 with the assessment reference date of 7/25/13 listed the brief interview for mental status score of 13, which indicated intact cognition. The resident had disorganized thinking which fluctuated in frequency and severity, had hallucinations (sensing things while awake that appear to be real, but instead have been created by the mind) and delusions (an untrue persistent belief or perception held by a person although evidence shows it is untrue) but displayed no behaviors. The resident received anti-psychotic medication daily.

The Care Area Assessment (CAA) dated 3/13/13 for cognitive loss listed diagnoses of intellectual disability (limitation in mental functioning), long term history of cyclic mental illness (a mental illness that varied in severity from time to time and duration of the episodes varied), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, forward flexion of the trunk, loss of postural reflexes and muscle rigidity and weakness), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), dementia, and anxiety (a mental

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or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The resident's diabetes was not well managed, fluctuated rapidly from highs to lows, became agitated with peers and or staff and often misunderstood what was said or what was going on around him/her. He/she often believed things were stolen, when they were most often misplaced and staff were able to locate them.

The CAA dated 3/13/13 for psychotropic medications listed the resident received Cymbalta (medication for depression), Latuda (used for paranoid schizophrenia) and as needed Klonopin (for anxiety). The resident's medication were changed and he/she no longer received Geodon or Seroquel. The resident had long history of mental illness, pharmacy completed medication review monthly, the resident was compliant with taking medications, the Abnormal Involuntary Movement screen severity was one (indicated little abnormal involuntary muscle movement). The resident displayed aggression, anxiety, and had difficulties with impulse control.

The care plan dated 8/8/13 for impaired cognition and thought process noted the resident had behaviors which included shouting at others, stomping off from a conversation, refusing to help to organize room to rest better and so the roommate would not trip, yelling at staff while they attempted to educate the resident, physically aggressive behavior and insomnia. Staff interventions included to discuss the resident's behaviors with him/her and if needed inform the physician if the resident's behaviors interfered with daily living. Staff to offer him/her a quiet area to go to when angry, observed who he/she sat next to at meals, activities, programming classes

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F 329	Continued From page 20 and public areas so the resident did not become provoked into aggression. Staff to offer medications as ordered, allow the resident time to look at the pills and to take them as he/she chose, to remind him/her to be courteous with peers and closely observe when the resident showed signs of agitation. Review of the August 2013 Medication Administration Record (MAR) revealed the following orders: Latuda 40 milligrams (mg) with supper for paranoid schizophrenia and identified as a Black Boxed Warning (BBW) medication Milk of Magnesia (MOM) 30 cubic centimeters (cc) PRN (as needed) for constipation According to the Federal Drug Administration (FDA) website the BBW for Latuda stated "warnings for increased mortality in elderly patients with dementia-related psychosis; and suicidal thoughts and behaviors. Elderly patients with dementia-related psychosis treated with anti-psychotic drugs are at an increased risk of death. Latuda is not approved for the treatment of patients with dementia-related psychosis". The facility provided information for Black Box Warning (undated) stated "numerous drugs have life threatening or dangerous side effects that may lead to organ/system damage and possible death. The FDA has added boxed warnings to the prescribing information for these drugs to alert health care professionals to the potential for serious side effects. A Black Box Warning covers considerations in particular situations and disease states in which the drug should be used with caution. Additional considerations are listed for use with pediatric, geriatric, pregnant or lactating clients".	F 329		

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F 329	Continued From page 21 The care plan did not list the BBW for Latuda. Review of the bowel and bladder elimination sheet from the electronic record revealed no documentation for a bowel movement (BM) on 2/26, 2/27, 2/28, and 3/1/13 for a total of four days no BM documented on 3/3, 3/4, 3/5, 3/6, and 3/7/13 for a total of 5 days, no BM documented on 4/7, 4/8, 4/9, and 4/10/13 for a total of 4 days, no BM documented on 4/29, 4/30, 5/1, and 5/2/13, for a total of 4 days, and no BM documented on 8/10, 8/11, 8/12, and 8/13/13 and no MOM given to the resident on any of these dates. Resident observed on 8/15/13 at 7:30 A.M. in the dining room, listening to country western music. At 8:05 A.M., the resident walked out of the dining room. On 8/15/13 at 1:25 P.M. observation revealed the resident walked back to his/her room, did propel slightly forward with a fairly rapid gait. Interview on 8/19/13 at 3:47 P.M. with licensed staff I said if a resident went 9 shifts without a BM then they were flagged in the computer and staff gave them MOM on the next shift, and if the resident had no results after the MOM then the staff would digitally check the resident for stool and then call the physician and get an order for a suppository. Interview with administrative nursing staff D on 8/19/13 at 4:28 P.M., revealed the resident did not have a BBW care plan for Latuda and it was noted in the resident's MAR as a BBW medication. He/she said everyday in stand up meeting we bring up the list of residents who	F 329		

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F 329	Continued From page 22 have not have a BM for 3 days and give that list to the nurses so they know who needed medication for their bowels. He/she confirmed the resident went 4 days without a documented BM and without any medication given to the resident for constipation during those days. The facility provided policy dated 2006 for bowel management program documented a daily bowel movement was not necessary, but a resident should not be allowed to go more than three days without a bowel movement. The facility failed to effectively monitor the anti-psychotic BBW medication, Latuda and failed to monitor BM and administer as needed medication for constipation for this resident.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This Requirement is not met as evidenced by: The facility identified a census of 55 residents. The sample was 14 residents, 5 of which were reviewed for medications. Based on observation, record review and staff interview, the facilities Pharmacy Consultant failed to identify lack of bowel movement monitoring for two residents (#13, #24) and failed to monitor black box	F 428		

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warning care plan for one resident (#13) of the sample.

Findings included:

- The electronic medical diagnosis dated 10-10-2012 for resident #24 listed constipation.

The 6-12-2013 Annual Minimum Data Set 3.0 documented the Brief Interview for Mental Status score of 15 which indicated cognition intact.

The 6-24-2013 Care Area Assessment (CAA) for Psychotropic Drug Use documented the resident took Senokot S routinely with PRN (as needed) Milk of Magnesia for constipation. The medication regimen review was completed monthly with last review done on 3-6-13, 4-4-13, 5-13-13, and 6-11-13 with no recommendations noted.

The electronic Physicians Order Sheet (POS) documented Senokot S 8.6-50 milligrams 1 tablet by mouth at bedtime everyday for constipation with the start date 10/7/2011.

The 1-6-2012 Care Plan for the resident at risk for constipation documented staff to make sure he/she had a bowel movement at least every three days and staff to give the resident medications as ordered, routine Senokot and PRN Milk of Magnesia.

The electronic Resident Continence Log revealed the resident did not have a bowel movement from 7-2-2013 through 7-5-2013 to equal a total of 4 days.

The clinical pharmacist's monthly medication regimen review summary dated 4-4-13 to 8-6-13

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lacked documentation regarding the lack of bowel movements.

Observation on 8-15-13 at 7:35 A.M. revealed the resident in the dining room verbally interacting with staff and residents in a pleasant conversation. At 1:34 P.M. revealed the resident in his/her room putting away their laundry.

Interview on 8-19-13 at 1:15 P.M., direct care staff O stated on each shift before it ended staff went around and asked the residents if they had a bowel movement. Staff chart the bowel movements on the kiosk machine (charting system) and on paper.

Interview on 8-19-13 at 2:39 P.M., direct care staff P stated every night staff went around and asked each resident if they had a bowel movement and then staff chart that on the kiosk machine.

Interview on 8-19-13 at 1:49 P.M., licensed nursing staff H stated staff asked residents about bowel movements. Staff documented bowel movements in care tracker (charting program). The protocol for bowel movements was if there was no bowel movement in the last nine shifts staff discussed this in the start up meeting; staff gave Milk of Magnesia if that did not work then a suppository was given and worse case scenario an enema was given.

Interview on 8-19-13 at 3:10 P.M., licensed nursing staff I acknowledged there was no bowel movement documented for four days (7/2/2013 through 7/5/2013) and stated I did not have any intervention documented for that time period.

Interview on 8-19-13 at 3:43 P.M., administrator

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nursing staff D stated sometimes the residents refused to tell us if they had a bowel movement. To my knowledge he/she had not had a problem. On the Clinical Startup check list dated 7-2-13, 7-3-13, 7-4-13 and 7-5-13 the resident was not on the list for not having a bowel movement. On the fourth day staff gave whatever the resident had ordered.

Interview on 8-20-13 at 4:36 P.M., Pharmacy Consultant HH stated, he/she did not review the care plans I just identify the black box warning medication. It was up to the facility to write the care plan and include the side effects and what it was about. The facility should have a bowel movement monitoring program every 3 days. I look for the use of prn medication that relieves constipation and medications that cause constipation. If the medication is unnecessary I will ask the physician to review it.

The facilities pharmacy consultant failed to identify the resident did not have a bowel movement over 3 days and the facility did not provide medications as ordered.

- The electronic physician order sheet (POS) for resident #13 dated 4/9/13 revealed the following diagnoses: gastroparesis (food remained in the stomach longer time than normal), paranoid schizophrenia (a psychotic disorder believed to be heavily influenced by anxiety or fear to the point of irrational thinking, fragmentation of thought, perception and emotional reaction), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), and dementia with behavioral disturbances (progressive mental disorder characterized by failing memory, confusion and also with behavioral symptoms).

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F 428	Continued From page 26 The quarterly Minimum Data Set 3.0 with the assessment reference date of 7/25/13 listed the brief interview for mental status score of 13, which indicated intact cognition. The resident had disorganized thinking which fluctuated in frequency and severity, had hallucinations (sensing things while awake that appear to be real, but instead have been created by the mind) and delusions (an untrue persistent belief or perception held by a person although evidence shows it is untrue) but displayed no behaviors. The resident received anti-psychotic medication daily. The Care Area Assessment (CAA) dated 3/13/13 for cognitive loss listed diagnoses of intellectual disability (limitation in mental functioning), long term history of cyclic mental illness (a mental illness that varied in severity from time to time and duration of the episodes varied), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, forward flexion of the trunk, loss of postural reflexes and muscle rigidity and weakness), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), dementia, and anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The resident's diabetes was not well managed, fluctuated rapidly from highs to lows, became agitated with peers and or staff and often misunderstood what was said or what was going on around him/her. He/she often believed things were stolen, when they were most often misplaced and staff were able to locate them.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175455	A. BUILDING _____ B. WING _____	08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ESKRIDGE	505 N. MAIN ST. ESKRIDGE, KS 66423

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F 428	Continued From page 27	F 428		

The CAA dated 3/13/13 for psychotropic medications listed the resident received Cymbalta (medication for depression), Latuda (used for paranoid schizophrenia) and as needed Klonopin (for anxiety). The resident's medication were changed and he/she no longer received Geodon or Seroquel. The resident had long history of mental illness, pharmacy completed medication review monthly, the resident was compliant with taking medications, the Abnormal Involuntary Movement screen severity was one (indicated little abnormal involuntary muscle movement). The resident displayed aggression, anxiety, and had difficulties with impulse control.

The care plan dated 8/8/13 for impaired cognition and thought process noted the resident had behaviors which included shouting at others, stomping off from a conversation, refusing to help to organize room to rest better and so the roommate would not trip, yelling at staff while they attempted to educate the resident, physically aggressive behavior and insomnia. Staff interventions included to discuss the resident's behaviors with him/her and if needed inform the physician if the resident's behaviors interfered with daily living. Staff to offer him/her a quiet area to go to when angry, observed who he/she sat next to at meals, activities, programming classes and public areas so the resident did not become provoked into aggression. Staff to offer medications as ordered, allow the resident time to look at the pills and to take them as he/she chose, to remind him/her to be courteous with peers and closely observe when the resident showed signs of agitation.

Review of the August 2013 Medication Administration Record (MAR) revealed the following orders:

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F 428	Continued From page 28 Latuda 40 milligrams (mg) with supper for paranoid schizophrenia and identified as a Black Boxed Warning (BBW) medication Milk of Magnesia (MOM) 30 cubic centimeters (cc) PRN (as needed) for constipation According to the Federal Drug Administration (FDA) website the BBW for Latuda stated "warnings for increased mortality in elderly patients with dementia-related psychosis; and suicidal thoughts and behaviors. Elderly patients with dementia-related psychosis treated with anti-psychotic drugs are at an increased risk of death. Latuda is not approved for the treatment of patients with dementia-related psychosis". The facility provided information for Black Box Warning (undated) stated "numerous drugs have life threatening or dangerous side effects that may lead to organ/system damage and possible death. The FDA has added boxed warnings to the prescribing information for these drugs to alert health care professionals to the potential for serious side effects. A Black Box Warning covers considerations in particular situations and disease states in which the drug should be used with caution. Additional considerations are listed for use with pediatric, geriatric, pregnant or lactating clients". The care plan did not list the BBW for Latuda. Review of the bowel and bladder elimination sheet from the electronic record revealed no documentation for a bowel movement (BM) on 2/26, 2/27, 2/28, and 3/1/13 for a total of four days, no BM documented on 3/3, 3/4, 3/5, 3/6, and 3/7/13 for a total of 5 days, no BM documented on 4/7, 4/8, 4/9, and 4/10/13 for a total of 4 days, no BM documented on 4/29, 4/30,	F 428		

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F 428	Continued From page 29	F 428		

5/1, and 5/2/13, for a total of 4 days, and no BM documented on 8/10, 8/11, 8/12, and 8/13/13 and no MOM given to the resident on any of these dates.

Review of monthly Drug Regimen Review from 4/4/13 to 8/6/13 revealed nothing noted related to bowel monitoring or to the BBW medications Latuda.

Resident observed on 8/15/13 at 7:30 A.M. in the dining room, listening to country western music. At 8:05 A.M., the resident walked out of the dining room.

Interview on 8/19/13 at 3:47 P.M. with licensed staff I said if a resident went 9 shifts without a BM then they were flagged in the computer and staff gave them MOM on the next shift, and if the resident had no results after the MOM then the staff would digitally check the resident for stool and then call the physician and get an order for a suppository.

Interview with administrative nursing staff D on 8/19/13 at 4:28 P.M., revealed the resident did not have a BBW care plan for Latuda and it was noted in the resident's MAR as a BBW medication. He/she said everyday in stand up meeting we bring up the list of residents who have not have a BM for 3 days and give that list to the nurses so they know who needed medication for their bowels. He/she confirmed the resident went 4 days without a documented BM and without any medication given to the resident for constipation during those days.

The facility provided policy dated 2006 for bowel management program documented a daily bowel movement was not necessary, but a resident

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F 428	Continued From page 30 should not be allowed to go more than three days without a bowel movement. A phone interview on 8/20/13 at 4:36 P.M. with Consultant HH said he/she reviewed the medications and identified medications with BBW and it was up to the facility to care plan the BBW for the medication and include the side effects. He/she said the facility should have a bowel monitoring program to include bowel monitoring for elimination every 3 days. Consultant HH said he/she reviewed medications used for relief of constipation for those that could cause constipation. Consultant HH failed to effectively monitor the anti-psychotic BBW medication, Latuda and failed to monitor the administration of as needed medication for constipation for this resident.	F 428		